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STATE OF DELAWARE

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

TELEPHONE: (302) 744-4500
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PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTIVE AUTHORITY

INSTRUCTIONS

When to File Prescriptive Authority Application

This is an application to be granted authority to prescribe by the Board of Medical Licensure and Discipline. File this application when:

- You have applied for a Delaware Physician Assistant license but chose not to apply for prescriptive authority at the same time.
- You already hold a Delaware Physician Assistant license but have not yet applied for prescriptive authority.
- You already hold a Delaware Physician Assistant license with prescriptive authority and are reporting change of:
  - Supervising physician(s)
  - Controlled substance schedules that you are authorized to prescribe

If you have not yet applied for your Delaware Physician Assistant license, STOP. Do not file this form. See *Application for a License to Practice as a Physician Assistant in Delaware*, available on www.dpr.delaware.gov, to apply for both Physician Assistant licensure and prescriptive authority.

Important Information about Controlled Substance Registration

If you receive prescriptive authority, you may prescribe ***only non-controlled substances***. To prescribe controlled substances in Delaware, you must have ***all*** of the following:

- Delaware PA license ***with*** prescriptive authority
- At least one supervising physician for *each* individual business/practice where you practice in Delaware
- Delaware CSR
  Note: If you practice at more than one business/practice, you need only a single CSR to ***prescribe*** at all of the locations. However, every Delaware location where controlled substances are dispensed/stored must be covered by a CSR. If no other practitioner (e.g., physician), physician assistant or APN holds a Delaware CSR for a location where you will ***store/dispense***, as well as prescribe, controlled substances, you must file for an additional CSR for the location.
- Federal DEA registration for Delaware (a DEA registration in another jurisdiction is not sufficient)

To apply for a CSR(s), see *Controlled Substances Application for Advanced Practice Nurses*, available on dpr.delaware.gov. For Federal DEA registration, see DEA New Registration Applications.

TYPE OF APPLICATION – To be completed by Physician Assistant

1. Select reason for submitting this form:

   ☐ I have applied for a Delaware Physician Assistant license but I did not apply for prescriptive authority at the same time.
   ☐ I already hold an active Delaware Physician Assistant license but I do not have prescriptive authority. Enter license number: **C5-** _____
   ☐ I already hold a Delaware Physician Assistant license, license number: **C5-** _____ and I *already have prescriptive authority*. I am reporting the following change:
      ☐ My supervising physician has changed. (This includes both new or additional supervisors.)
      ☐ The controlled substance schedules that I am authorized to prescribe has changed.

2. I am applying for prescriptive authority for:

   ☐ Controlled and Non-Controlled Substances ☐ Non-Controlled Substances Only

   ***Alert*: This is NOT an application for Controlled Substance Registration. See Instructions.**

IDENTIFYING AND CONTACT INFORMATION – To be completed by Physician Assistant

3. Full Name: _____ _____ _____
   Last First Middle

4. Other Names Used: _____ _____ _____

5. Mailing Address: _____

_____ _____ _____
City State Zip

6. Phone: _____ _____ Email: _____ ☐ None
Home Work

LOCATION OF PRACTICE – To be completed by Physician Assistant

7. Complete the following information about ***each*** individual business/practice where you will be practicing in Delaware.

FIRST PRACTICE

Business/Practice Name: _____

Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____
City State Zip

Business Phone: _____ Email: _____

Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

PRACTICE 2

Business/Practice Name: _____

Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____
City State Zip

Business Phone: _____ Email: _____

Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

PRACTICE 3

Business/Practice Name: _____

Location Address: _____
(If more than one location, enter main location. *No PO Box!)*

_____ DE _____
City State Zip

Business Phone: _____ Email: _____

Will you be prescribing controlled substances at any location of this business/practice? Yes ☐ No ☐

If you need more room to list additional Delaware business/practice(s), provide the same information on a separate sheet and enclose it with the application.

8. Enter the names of ***all*** physicians who will supervise you, regardless of business/practice or location:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Arrange for *each* supervising physician you listed above to submit a *Statement of Supervising Physician* (see next page). Enclose all statements with the application.

9. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

If you have additional supervising physicians, you may copy this page.

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____

2. Delaware Physician License Number: **C** ___-_____ 3. Specialty: _____

4. DEA Numbers: _____ _____
   Federal Delaware

5. Which controlled substance schedules are you authorized to prescribe? ☐ II ☐ III ☐ IV ☐ V

6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe *under your supervision*?** ☐ II ☐ III ☐ IV ☐ V

7. Are you delegating authority to the Physician Assistant applicant to request and issue professional samples of controlled legend medications? Yes ☐ No ☐ **If yes, as the supervising physician, you remain ultimately responsible for prescribing, dispensing and storing the controlled substances even though you are delegating authority to the PA.**

8. **As the supervising physician, I understand that I may not at any given time supervise more than four physician assistants, unless a regulation of the Board increases or decreases the number (24 *Del C.* §1771(e)).** Yes ☐ No ☐

9. How many Physician Assistants do you currently supervise? _____

10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

Signature of Supervising Physician: _____ Date: _____

STATEMENT OF SUPERVISING PHYSICIAN

1. Name of Supervising Physician: _____

2. Delaware Physician License Number: **C** ___-_____ 3. Specialty: _____

4. DEA Numbers: _____ _____
   Federal Delaware

5. Which controlled substance schedules are you authorized to prescribe? ☐ II ☐ III ☐ IV ☐ V

6. **Which controlled substance schedules is the Physician Assistant applicant authorized to prescribe *under your supervision*?** ☐ II ☐ III ☐ IV ☐ V

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10. I understand that I must promptly submit a new *Application for Prescriptive Authority* to notify the Board of Medical Licensure and Discipline of any change in supervising physician(s) or schedule(s) authorized. Yes ☐ No ☐

Signature of Supervising Physician: _____ Date: _____

CERTIFICATION

I declare and affirm under penalty of perjury that the foregoing statements are true and complete to the best of my knowledge.

Signature of Physician Assistant: _____ Date: _____